ORTHOPAEDIC SPECIALISTS

Better experience. Better results.

3385 Dexter Court, Suite 300, Davenport, IA 52807
(563)344-9292 Office (563)344-9573 Fax

MEDICAL RECORDS RELEASE

Patient's Full Name: _____ **DOB:** _____ **Phone #:**_____
Patient's Former Name (if applicable):_____

PATIENT AUTHORIZES ORTHOPAEDIC SPECIALISTS TO (*COMPLETE ONLY ONE BOX*):

RECEIVE RECORDS FROM:	**SEND RECORDS TO:**
Name _____	Name _____
Address _____	Address _____
City/State/Zip_____	City/State/Zip _____
Phone _____Fax _____	Phone _____ Fax _____

PURPOSE OF DISCLOSURE

☐ Continuing Care ☐ Insurance ☐ Legal ☐ Personal Use

☐ Transfer of Care ☐ Other (Please specify): _____

RECORDS TO INCLUDE:

- ☐ **Paper records to include (Choose 1 from options below):**
  - □ Entire chart
  - □ Specific body part_____
  - □ Date Range_____
- ☐ **X-Ray Disc (outside imaging exams must be obtained from the performing facility)**

DISCLOSURE OF SENSITIVE INFORMATION

I understand that my health record may contain sensitive information relating to my condition(s). This includes, but is not limited to, information pertaining to sexually transmitted disease, human immunodeficiency virus (HIV), acquired immunodeficiency syndrome (AIDS), behavioral or mental health services and treatment for alcohol and drug abuse.

By checking here, I choose to exclude the above types of information from this disclosure. ☐

TERMS AND CONDITIONS

- I have the right to revoke this Authorization, in writing, at any time by notifying the administration at Orthopaedic Specialists, P.C., and the health care provider being requested to disclose health information (if applicable). Such revocation will not apply to information that already had been disclosed in reliance of this Authorization.
- I have the right to not sign this Authorization. Orthopaedic Specialists, P.C. will not condition treatments, payment for services or enrollment or eligibility for benefits on whether I sign this Authorization.
- If health information is disclosed to a person who is not covered by federal or state confidentiality laws, there is the potential for this information to be subject to re-disclosure and no longer be protected by these laws.
- I have read and understand this Authorization; have had an opportunity to have my questions answered; have signed this Authorization freely and have received a copy of this Authorization, if desired.
- Please note, this authorization expires (1) year after the date of signature unless otherwise specified: _____

SIGNATURE: _____ **DATE:** _____

PRINT NAME: _____ **SIGNED BY:** ☐ **Patient** ☐ **Parent** ☐ **Legal Representative**